Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

UNIVERSITY HEALTH SYSTEM
4502 MEDICAL DR
SAN ANTONIO TX 78229-4402

Respondent Name
VALLEY FORGE INSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 47

MFDR Tracking Number
M4-08-4356-02

MFDR Date Received
March 4, 2008

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "the claim was denied for unrelated to non-covered service, this patient came through the emergency room with back pain and leg pain, UHS treated patient with all service need for this patient. University Health System has received a denial on this appeal for non covered service, insurance company is not taking responsibility of the injury worker medical bills and this clearly a work relate injury."

Amount in Dispute: $32,776.18

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier is not liable for reimbursement because Provider did not obtain preauthorization."

Response Submitted by: Stone Loughlin & Swanson, LLP, 3508 Far West Blvd., Suite 200, Austin, Texas 78731

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
December 4, 2007 to December 19, 2007	Inpatient Hospital Services	$32,776.18	$13,050.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.2 defines words and terms related to medical billing and processing.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.401 sets out the fee guidelines for acute care inpatient hospital services.
4. 28 Texas Administrative Code §134.600 sets out guidelines for prospective and concurrent review of health care.
5. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.

6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W12 – Extent of injury. Not finally adjudicated.
   - 880-125 – DENIED PER INSURANCE: NC (NON – COVERED) PROCEDURE OR SERVICE. 100%
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 920-002 – IN RESPONSE TO A PROVIDER INQUIRY, WE HAVE RE-ANALYZED THIS BILL AND ARRIVED AT THE SAME RECOMMENDED ALLOWANCE.
   - 39 – Services denied at the time authorization/pre-certification was requested.
   - 855-004 – SERVICE(S) NOT REIMBURSED AS THE PRE-AUTHORIZATION REQUEST WAS DENIED BY THE CARRIER (RULE 133.6000) $0.00

Issues

1. Are there any unresolved issues related to extent or compensability of the injuries?
2. Are there any unresolved issues related to medical necessity for the disputed services?
3. Was preauthorization required for the hospital admission?
4. Was preauthorization required for the spinal surgery?
5. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied disputed services with reason codes 880-125 – "DENIED PER INSURANCE: NC (NON – COVERED) PROCEDURE OR SERVICE. 100%"; and W12 – "Extent of injury. Not finally adjudicated." On May 11, 2009 the Division issued a decision and order in regards to contested case hearing Docket No. SA-08-158477-01-CC-HD45, which settled the matter of extent, concluding that "The compensable injury . . . extends to include cervical spine, thoracic spine, and lumbar herniated nucleus pulposus at L3-4 with radiculopathy." The Division takes notice of the findings and conclusions of the decision and order in the above contested case hearing. Subsequent to the hearing, the health care provider resubmitted the disputed bills to the insurance carrier. Upon reconsideration, the insurance carrier denied the services instead for reasons related to preauthorization. Review of the submitted documentation finds that there are no unresolved issues related to compensability or extent of injury.
2. Review of the submitted explanations of benefits finds no denial codes related to the medical necessity of the disputed services. Upon further review of the submitted documentation the Division concludes that there are no unresolved issues related to the medical necessity of the disputed services.
3. 28 Texas Administrative Code §134.600(c), effective May 2, 2006, 31 *Texas Register* 3566, provides, in pertinent part, that "The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions); (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care."

   §134.600(p) states that "Non-emergency health care requiring preauthorization includes: (1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay."

   There is some documentation to support that the health care provider sought retroactive preauthorization after the fact of admission, and that the insurance carrier denied this request. However, this documentation is irrelevant to the matter under consideration. §134.600(a)(7) defines preauthorization as "prospective approval obtained from the insurance carrier . . . by the requestor or injured employee . . . prior to providing the health care treatment or services (health care)." Thus it was inappropriate for the insurance carrier to submit the services, after the fact, for retrospective utilization review. Authorization may be considered only prospectively. Consequently, any retrospective determinations fail to meet the requirements of the rule and are ineligible for consideration in this review.

   28 Texas Administrative Code §133.2(3)(A), effective May 2, 2006, 31 TexReg 3544, defines a medical emergency as: "the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient's health or bodily functions in serious jeopardy, or (ii) serious dysfunction of any body organ or part."

   The Division notes that the rule does not require that the patient actually *be* in jeopardy or *suffer* serious dysfunction. Rather, what is required is that the patient manifest acute *symptoms* of such severity (including severe pain) that the health care provider, prior to treatment and *without the benefit of hindsight*, could reasonably expect the patient to be in jeopardy or to suffer serious dysfunction without further attention.

Review of the Emergency Physician Record finds that the injured employee presented to the emergency room manifesting acute symptoms including sharp and burning pain in the back and radiating down the leg. On a pain scale of 1-10, a 10 is documented.

The submitted documentation clearly supports that at the time of admission to the hospital, the injured worker manifested acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health or bodily functions in serious jeopardy, or serious dysfunction to the injured employee's body parts or organs. This meets the definition of a medical emergency. As a medical emergency was supported at the time of admission, the admission to the hospital did not require pre-authorization. Subsection 134.600(c)(1)(B) is not applicable to the hospital admission. The applicable rule is §134.600(c)(1)(A); the carrier is liable because an emergency situation had occurred as defined in Chapter 133. As preauthorization was not required, the insurance carrier's denial code is not supported. The disputed services related to the hospital admission and the entire length of stay will therefore be reviewed for payment according to applicable Division rules and fee guidelines.

4. Review of the submitted documentation finds that the disputed services also include a spinal surgery. §134.600(p)(3), however, requires that the health care provider obtain a separate authorization for non-emergency spinal surgery. The hospital did request preauthorization for the spinal surgery; however, upon utilization review, the request for preauthorization of the spinal surgery was denied. No documentation was found to support that the health care provider sought reconsideration or review of the denial. Review of the submitted information finds insufficient documentation to establish that the patient manifested acute symptoms of sufficient severity, including severe pain, that the absence of immediate spinal surgery could reasonably be expected to result in placing the patient's health or bodily functions in serious jeopardy, or serious dysfunction to the injured employee's body parts or organs. Neither an emergency nor preauthorization are supported with respect to the spinal surgery. Accordingly the insurance carrier's denial reason related to preauthorization of the spinal surgery services is supported. Reimbursement cannot be recommended for the spinal surgery services and the charges for those services will not be considered in the review of other payable services.
5. This dispute relates to inpatient hospital services with reimbursement subject to the provisions of the Division's former *Acute Care Inpatient Hospital Fee Guideline* at 28 Texas Administrative Code §134.401, effective August 1, 1997, 22 *Texas Register* 6264. As the surgical services are not eligible for payment, the remaining gross charges for the hospital admission do not exceed the $40,000 minimum stop-loss threshold as set forth in §134.401(b)(6)(A)(i), therefore, the services do not qualify for stop-loss reimbursement under §134.401(b)(6). Neither does the admission qualify as a surgical admission, but will rather be considered as a medical admission for the purpose of calculating the per diem. The standard medical per diem amount of $870 multiplied by the length of stay of 15 days yields a reimbursement amount of $13,050.00. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $13,050.00. This amount is recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that additional reimbursement is due. As a result, the amount ordered is $13,050.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $13,050.00, plus applicable accrued interest per 28 Texas Administrative Code §134.803, due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	December 20, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.